Multiple Sclerosis Self-Injectable Agents (A-D)

(Avonex®, Betaseron®, Copaxone®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: 1151 Old York Road
Apt/Suite: 200 City: Abington State: PA Zip: 19001
Contact: _____
Phone: 215-957-9250 Alternate: _____
Fax: 215-957-9254
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ _____ Diagnosis Date: _____
Type: ☐ Clinically isolated syndrome ☐ Relapsing-remitting ☐ Secondary-progressive ☐ Primary-progressive ☐ Progressive-relapsing
Hepatic Impairment present: ☐ Yes ☐ No AST: _____ U/L ALT: _____ U/L Bilirubin: _____ mg/dL Lab date: _____
Pre-existing hepatic conditions: ☐ HBV ☐ HCV ☐ _____ TB Test: ☐ Positive ☐ Negative Test date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription		Quantity		Refill
☐ **Avonex®** (interferon beta-1a)	☐ Week 1: Inject 7.5 mcg (0.125 mL) intramuscularly once weekly; Week 2: Inject 15 mcg (0.25 mL) intramuscularly once weekly; Week 3: Inject 22.5 mcg (0.375 mL) intramuscularly once weekly; Week 4: Inject 30 mcg (0.5 mL) intramuscularly once weekly	☐ 4 x 30 mcg	PFS	0
	☐ Inject 30 mcg intramuscularly once weekly	☐ 4 x 30 mcg	☐ Pens ☐ PFS ☐ Vials	_____
☐ **Betaseron®** (interferon beta-1b)	☐ Week 1-2: Inject 0.0625 mg (0.25 mL) subcut every other day; Week 3-4: Inject 0.125 mg (0.5 mL) subcut every other day.	☐ 14 x 0.3 mg	Vials	0
	☐ Week 5-6: Inject 0.1875 mg (0.75 mL) subcut every other day; Week 7-8: Inject 0.25 mg (1 mL) subcut every other day.	☐ 14 x 0.3 mg	Vials	0
	☐ Inject 0.25 mg (1 mL) subcut every other day	☐ 14 x 0.3 mg	Vials	_____
☐ **Copaxone®** (glatiramer acetate)	☐ Inject 20 mg subcut once daily ☐ Inject 40 mg subcut three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	_____
☐ **Glatiramer Acetate**	☐ Inject 20 mg subcut once daily ☐ Inject 40 mg subcut three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	_____
☐ ***WhisperJECT***™	☐ Autoinjector for use with Glatiramer Acetate (manufacturer limit of one per year)	☐ 1 unit	Delivery Device	0
☐ **Glatopa**™ (glatiramer acetate)	☐ Inject 20 mg subcut once daily ☐ Inject 40 mg subcut three times per week at least 48 hours apart	☐ 30 x 20 mg ☐ 12 x 40 mg	PFS	_____

§Extavia®, Plegridy®, Rebif® are available on the Multiple Sclerosis - Self-Injectable Agents Enrollment Form E-Z §

Injection Training Provided by: ☐ Prescriber's Office ☐ Pharmacy ☐ Other: _____

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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